Who Owns the Hospital?

Private equity, nonprofit conversions, and what Lane County is not allowed to see.

Remarks to the League of Women Voters of Lane County · September 22, 2026 · Marty Wilde

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> These are my remarks as delivered, lightly edited for reading and with source citations added. Every figure comes from a public filing, and the endnotes say which one. Where I draw an inference rather than report a fact, I have tried to say so.
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> I am grateful to the committee for *Health Care Disparities in Lane County*, which prompted this talk and supplied its best exhibit.

Thank you for having me. For those who don't know me, I am an attorney, a former legislator, a former executive director of the Lane County Medical Society, and a current doctor's spouse. I write a Substack called *Letters from a Recovering Politician*. It didn't start out as a years-long critique of Oregon's healthcare woes, but here we are.

I read your report, so let me start with the best thing in it, which is the table built from data provided by the Oregon Office of Rural Health. It measures primary care capacity against primary care demand. A ratio of 1.0 means supply meets demand. The Eugene University area sits at 1.80. Springfield is at 1.58.[1]

Triangle Lake, where I grew up, is at zero. Dr. Mentzer retired and no one took his place.

Most rural communities aren't much better. Veneta is at 0.11. Oakridge at 0.16.

How did this come to pass? Let's look at obstetric services in Springfield, the McKenzie-Willamette nonprofit transition, and Peace Harbor's money troubles, and see whether there are common threads.

One more number next to that table

In the third quarter of last year, McKenzie-Willamette Medical Center delivered 143 babies. In the fourth quarter it delivered 55. In the first quarter of this year, 36. The hospital had delivered 619 in all of 2024.[2]

Lane County's total births barely moved across that time. RiverBend absorbed nearly all of the shift, providing care for 22 percent more births. Notably, the labor and delivery unit at RiverBend had drawn nurse staffing complaints before the increase.

Here is what happened. In July of 2025, six obstetrician-gynecologists left Oregon Medical Group, three of them leaving the state. The practice held the contract covering the birth unit at McKenzie-

Willamette, and when it closed its obstetrics department that contract ended in November. Expectant mothers received letters telling them to find a new provider.[3]

Oregon Medical Group is owned by Optum, which is owned by UnitedHealth Group, headquartered in Minnetonka, Minnesota. The practice went from physician-owned to corporate, and the consequences are still rippling through our community.

Four structures

Capital almost never enters health care by buying a hospital and running it badly. It enters through four structures that move money without appearing to move care.

The first is **debt**. A buyer borrows against the hospital, and the hospital carries the loan rather than the buyer, which puts interest ahead of nurses and ahead of beds.

The second is the **management fee**, where a parent charges its own subsidiary for shared services under a contract between two parties in common control. That contract is almost never public.

The third is **cost allocation**, which is the quiet giant. Corporate overhead gets spread across facilities by formula, and whoever writes the formula gets to decide which subordinate hospitals appear profitable and which risk closure.

The fourth is the **staffing intermediary**, where a hospital stops employing its physicians and contracts instead with a management services organization. Doctors who have known a community for decades become a line item that can be re-bid.

Every one of those is lawful, and each has a potentially respectable business purpose. A chain really does provide purchasing and billing and information technology, and somebody has to pay for it.

But each of these mechanisms lives inside a document the public cannot read, and each determines whether a service survives.

Mencken had a line for this in 1917, about something else entirely.[4]

> Explanations exist; they have existed for all time; there is always a well-known solution to every human problem, neat, plausible, and wrong.

The neat and plausible explanation for a closed rural service is that the hospital lost money. But that answer is also wrong in many cases, and I want to show you where the number comes from.

Oregon Medical Group

Your study got this right. Physicians described being limited to ten minutes a patient, pressure to code for every prior diagnosis rather than the one that brought the person in, and panels of twenty-two hundred.

Let me take it a step further. In January of 2025, the Oregon Health Authority found Oregon Medical Group's spending growth for privately insured patients running about 6.8 percent, roughly double the state target, with no valid justification offered.[5]

There is nothing fundamentally wrong with an insurer owning a medical practice. Kaiser Permanente has done it here for years without the disruption we have seen elsewhere. But when the purpose shifts from the provision of healthcare to the extraction of profit from a community, it can go very wrong. In my view, it did at Oregon Medical Group.

McKenzie-Willamette

The proposed conversion of McKenzie-Willamette into a nonprofit is the largest health care transaction in this county's history, and it is pending before the state as I write.

Your history of the hospital runs from the 1948 flood through the 2004 split with Cascade Health, and it is the clearest account of that period anyone has written down. Let me carry it forward.

Quorum Health owns McKenzie-Willamette today. Quorum runs eleven hospitals in nine states, down from twenty-four when it filed for bankruptcy in 2020, and it sits under a holding company called Quincy Health, LLC, whose largest investor is GoldenTree Asset Management in New York. In August, Quorum filed with the Oregon Health Authority to transfer the entire chain to a newly formed nonprofit, QKA Health Corporation, doing business as Healthside Partners.[6]

The transaction is valued at $956.7 million. It is filing 089 on the state's Health Care Market Oversight docket, and the comment period is open now.

The first thing to say is that the conversion may well be good news. As a for-profit, McKenzie-Willamette is not required to provide free care below 200 percent of the federal poverty level, or sliding-scale discounts up to 400 percent, as nonprofit hospitals are under ORS 442.614. Converting would put Springfield's oldest hospital under a charity care floor for the first time in twenty years.[7]

But look under the hood, and the picture is less tidy.

Quorum pays about 10.36 percent on its senior debt. That debt carries so high a rate because the company emerged from bankruptcy. Through tax-exempt bonds the new nonprofit expects roughly 8.25 percent, cutting the annual interest bill from $135.9 million to $104.9 million. The company does not hide this. It tells the state the interest saving is a primary motivation.[8]

Here is the detail I would put on a billboard. The new bonds are anticipated to be interest-only for the first five years after closing. Payments fall by about $31 million a year, and not one dollar of principal is retired. It is the minimum payment on a credit card, if the credit card were a hospital.

So where does Springfield's money go?

For two of the last three fiscal years, McKenzie-Willamette made money on its operations. It finished in the red only after Quorum charged it a corporate management fee.

MCKENZIE-WILLAMETTE MEDICAL CENTER, BEFORE AND AFTER THE CORPORATE FEE

	FY2023	FY2024	FY2025
Net revenue	$256.0M	$274.1M	$273.3M
Result before corporate fee	$6.9M	$5.4M	($14.9M)
Management fee paid to Quorum	($9.2M)	($8.9M)	($9.8M)
Bottom line	**($2.4M)**	**($3.5M)**	**($24.7M)**

Source: Exhibit G-2, McKenzie-Willamette financial statements filed with the Oregon Health Authority, HCMO transaction 089.

About $27.9 million left the hospital as management fees over three years. Over that same period, the money the hospital owed to affiliated Quorum entities climbed from $137.8 million to $150.7 million, and the hospital's own cash line runs below zero, which is what happens when a parent sweeps the account every night.[9]

Nine million a year may be a perfectly fair price for purchasing, billing, and information technology. It may even be a bargain. I would simply like to see the receipt, and I cannot, because the management agreement was withheld from the public file in full.[10]

As for who gets paid, a 2024 amendment handed Quorum's lenders 27.5 percent of the company's equity, so the creditors and the owners are now substantially the same people. BlackRock wrote its stake in the parent down to zero in April. That equity is worth nothing today, and access to the municipal bond market is how it stops being worth nothing. Put another way, investors made a bad investment, and the conversion is how they recover what they can of it.[11]

Why does that matter to you? Because if the property tax exemption is granted, the hospital's property comes off the tax rolls. That money currently goes to police, fire, schools, and the other services that make Springfield a place people want to live.

Which brings me to the part that lands in Eugene

Your report notes the planned freestanding emergency department. The state file adds detail. Capital cost above $20 million. Land identified, design begun, conditional use permit approved in May.

Then this sentence, which is the company's and not mine.[12]

> If the conversion to non-profit status and the related bond raise are not successful, QHC's funding of the project will be in jeopardy.

Eugene's next emergency room depends on a bond sale that has not happened yet. That is the applicant's own framing of the stakes, and I would encourage the Oregon Health Authority to convert it into an enforceable commitment rather than an expectation.

One more thing about that file. Seventeen documents are withheld from public inspection, including the valuation behind the $956.7 million figure, the feasibility study, the parent's financial statements, the management agreement, both organizational charts, and the board minutes. Compensation for the new nonprofit's leadership is redacted.[13]

It is worth considering the alternative, which is another bankruptcy. Quorum might pursue a liquidation, causing the hospital to crash out of the local market. The company reports that it solicited buyers and received no acceptable offers. I would note, as an inference rather than a fact, that no acceptable offers is not the same as no offers.

Reorganization seems more likely. In that scenario the hospital's creditors, who are also at least partly its owners at this point, take the loss while the hospital keeps operating. From that perspective, the people who lose are the ones who thought lending a bankrupt company money at over 10 percent was a good idea, rather than the public.

PeaceHealth

Two things here, and the first is an ending to a story your committee was writing while it was still in progress.

When your Local Issues chapter was drafted, the ApolloMD transition was pending, with July 1 set as the changeover and the litigation still moving.

PeaceHealth reversed in May and restored the Eugene Emergency Physicians contract. Oregon's corporate practice of medicine law was central to that outcome. And on September 16, Senators Wyden and Merkley and Representative Hoyle introduced the Stop Corporate Takeovers of Physicians Act, modeled on our state law, with the Eugene fight as its origin story. Representative Hoyle noted that 80 percent of American physicians now work for corporations, up from 62 percent in 2019.[14]

Forty-one emergency physicians stood their ground against a corporate takeover, and it worked twice.

Now the harder part, which is that none of this requires a villain from Atlanta.

Peace Harbor in Florence is a 21-bed critical access hospital and the only hospital on that stretch of coast. On the numbers PeaceHealth files with Oregon, it has lost money in eight of the last nine fiscal years, about $77 million since 2017.[15]

The accounting behind that figure repays a close reading. For the year ending June 30, 2025, PeaceHealth described the same twelve months two different ways.

- To Oregon, operating expense of $134.0 million and a net loss of $20.4 million.
- To Medicare, for the identical period, operating expense of $113.3 million and net income of about $127,000.

The revenue lines in the two filings match almost to the dollar.[16]

This is not an accusation of fraud, and I want to be clear about that. The two forms define operating expense differently, and a hospital can file both in good faith. The gap is close in size to home office cost booked differently on each. It is still a $20 million swing between two government filings, in a year when the reported loss is the entire argument for what happens to that hospital.

Twain got there first.[17]

> Figures often beguile me, particularly when I have the arranging of them myself.

The formula

PeaceHealth has explained, in writing, that it allocates system overhead to each facility as a percentage of that facility's net patient revenue, and that the size of each revenue base is what produces the variance between facilities. That is a checkable claim. Every PeaceHealth hospital files a Medicare cost report, and one page of it states what the parent charged that hospital. Nine filed for the year ended June 30, 2025. If a single percentage governs, one rate should appear nine times.

HOME OFFICE COST CHARGED TO PEACEHEALTH HOSPITALS, YEAR ENDED JUNE 30, 2025

Hospital	Net patient revenue	Home office cost	Rate
Sacred Heart RiverBend, OR	$1,025.1M	$204.5M	19.9%
St. Joseph, Bellingham, WA	$935.7M	$178.4M	19.1%
Southwest, Vancouver, WA	$934.5M	$203.1M	21.7%
St. John, Longview, WA	$399.2M	$83.0M	20.8%
United General, WA *(critical access)*	$104.6M	$24.0M	22.9%
Ketchikan, AK *(critical access)*	$98.7M	$23.1M	23.4%
Peace Island, WA *(critical access)*	$29.9M	$7.3M	24.3%
Peace Harbor, Florence, OR *(critical access)*	**$110.1M**	**$37.0M**	**33.6%**
Cottage Grove, OR *(critical access)*	**$55.0M**	**$20.6M**	**37.4%**

Source: CMS Healthcare Cost Report Information System, Form 2552-10, Worksheet A-8-1 line 500 and Worksheet G-3 line 3, fiscal years ended June 30, 2025.

One rate does not appear nine times. Every hospital in the system falls between 19 and 24 percent, including the critical access hospitals in Washington, and including Ketchikan, Alaska, which is

about as remote as an American hospital gets. The two exceptions are both in Oregon. The difference between Peace Harbor's rate and RiverBend's accounts for roughly three-quarters of Peace Harbor's reported operating loss.

Two legitimate explanations deserve a hearing. Worksheet A-8-1 captures every category of home office cost, not only the services PeaceHealth listed, so if the Oregon hospitals fold in more employed-physician clinic work than the others, part of the gap reflects what those hospitals do rather than how the parent charges them. Peace Harbor's medical group home office line runs about $8 million of its $37 million. Remove it entirely and Florence still sits near 26 percent, above every large hospital in the system.

The second explanation has nothing to do with Florence. Medicare pays critical access hospitals on a cost basis, so assigning more allowable cost to one raises federal reimbursement on the Medicare share of its patients. That is lawful and widely done. It also means the allocation answers a reimbursement question rather than measuring what Florence consumed, and the resulting figure is what lands on the state form as a loss.

There is a finding that cuts the other way, and it should be said plainly. Home office interest and capital cost reached three PeaceHealth hospitals last year and none of the five critical access hospitals. RiverBend was charged $16.6 million in interest. Peace Harbor was charged nothing. Peace Harbor's reported result therefore excludes a cost its larger sister hospitals carry, which understates rather than inflates its loss.[18]

The point is not that the loss is manufactured. The point is that operating overhead flows down to the critical access hospitals at a premium rate while capital cost does not flow down to them at all, and the same party decides both.

One more note on the accounting

The common answer from nonprofits to questions like these is to point to the charity care they provide. But the central office also decides, at least in part, how those figures are assigned. Between FY2024 and FY2025, subsidized health services reported at Peace Harbor rose from about $400,000 to more than $5.2 million.[19]

Part of that is definitional. Subsidized health services are measured by the loss a hospital reports on a service line, so a larger reported loss produces a larger community benefit figure automatically. Which is rather the point. The same reported loss that would justify closing a service counts toward the state's community benefit floor while the service stays open.

Your report places the private equity firms and the insurers in one chapter. I would only add that the same four mechanisms work perfectly well inside a religious nonprofit, and one of them is working on the Oregon coast this morning. An entity outside the community is deciding what an entity inside the community owes it.

Florence is entitled to know how much of its hospital's loss was actually earned in Florence.

What holds these together

In each of these cases, documents exist that would settle the questions I have raised. The management agreement. The allocation methodology. The valuation.

The public gets to see none of them.

Two structural problems make this worse in Oregon. The state's market oversight program reviews transactions above a dollar threshold, so a series of small clinic acquisitions can reshape a county without any single deal triggering review. And the facility-level financial filings Oregon once published no longer resolve to the same level of detail. The hospital profile page for Peace Harbor now sends a reader to PeaceHealth's own materials.

There is a counterexample, and it is ours. Senate Bill 951 gives Oregon the strictest limits in the country on corporate control of medical practice, and deals of this kind fell nearly 36 percent nationally this summer, with our law named as a reason.[20]

Two footnotes on that. The law reaches arrangements that existed before June 2025 only in January 2029, so a good deal of what I have described stays lawful here for another two years. And it is enforced by private lawsuit rather than by any agency, which makes it a right that belongs, in practice, to people who can afford litigation.[21]

What I would ask of you

Comment on the Quorum conversion. Preliminary review is open, and comments go to **hcmo.info@oha.oregon.gov** with the word *Quorum* in the subject line. Four things are worth asking for.

- A written charity care floor specific to McKenzie-Willamette.
- A binding construction deadline for the Eugene emergency department, with a remedy if it is missed.
- Advance notice to the state before any Oregon service line is reduced or closed.
- Reserved voting seats for Lane County residents on the new governing board.

These dockets receive very few public comments. A letter from an informed local resident is not a drop in an ocean. It is frequently one of four things in the file.

Three more, for the longer term.

- Ask the Oregon Health Authority to require disclosure of cost allocation methodology as a condition of accepting a hospital's financial filings, so that a margin in Florence means what a

margin in Springfield means.

- Ask the legislature to give Senate Bill 951 an enforcement agency before January 2029 arrives.
- Ask Oregon to restore public access to individual hospital financial filings.

Let me finish where I started, with your table.

Triangle Lake at zero is not an accident, and it is not anyone's crime. It is the accumulated result of many small decisions, probably all lawful, most of them rational for the people who made them, and almost none of them made by anyone who has driven Highway 36 in the rain.

The question in front of this county is not whether somebody broke a rule.

It is whether our rules require anyone to tell us what we are buying.

Thank you for the chance to speak with you, and for all the work you do in our community.

Disclaimer. The views expressed here are those of the author and not necessarily those of the Department of the Navy, the Department of Defense, the University of Oregon, or any other entity with which the author is affiliated. No government time or resources were used in preparing these remarks.

The author submitted a public comment on PeaceHealth's Timber Springs certificate of need application (CN #714) in August 2026. Where these remarks rely on representations made in the press or in regulatory filings, some facts may remain in dispute.

Marty Wilde writes *Letters from a Recovering Politician* at martywilde.substack.com.

Sources

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2. Oregon Health Authority, Hospital Financial and Utilization Databank, births by hospital and quarter, Q1 2007 through Q1 2026.
3. KLCC, "OB-GYNs quit Oregon Medical Group, affecting birth plans for some expecting moms in Eugene-Springfield area" (October 6, 2025).
4. H. L. Mencken, "The Divine Afflatus," *New York Evening Mail* (November 16, 1917).
5. Oregon Health Authority cost growth target program findings, January 2025; reported in OPB, "OHA flags Eugene-based medical group, 2 insurers for excessive spending" (January 25, 2025).
6. Oregon Health Authority, Health Care Market Oversight transaction 089 (Quorum–Healthside), Exhibit A, Notice of Material Change Transaction; and Exhibit P, QKA Form 1023.
7. ORS 442.614.
8. HCMO 089, Notice of Material Change Transaction, and the applicants' August 14 and August 28, 2026 responses to the Oregon Health Authority's request for information.
9. HCMO 089, Exhibit G-2, McKenzie-Willamette Medical Center financial statements.
10. HCMO 089, Exhibit J, Management Agreement (withheld in full).
11. HCMO 089, applicants' responses regarding the 2024 credit agreement amendment and equity allocation; BlackRock valuation as of April 30, 2026.
12. HCMO 089, Project 12 RFI clarification (public version).
13. HCMO 089, Exhibit L, HCMO Redaction Log.
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16. Oregon Health Authority FR-3 filing for the year ended June 30, 2025, compared with CMS Form 2552-10 cost report for Peace Harbor Medical Center (CCN 381316), identical period.
17. Mark Twain, *Chapters from My Autobiography*, *North American Review* (1907).
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19. Oregon Health Authority Community Benefit Dataset, subsidized health services reported for Peace Harbor Medical Center, FY2024 and FY2025.
20. PitchBook data on second-quarter 2026 management services organization transactions, reported in Lookout Eugene-Springfield, "Oregon law among policies slowing private equity healthcare deals in U.S., report finds" (August 19, 2026).
21. Oregon Senate Bill 951 (2025), signed June 9, 2025. Management services organizations formed on or after that date are covered beginning January 1, 2026; arrangements predating it have until January 1, 2029 to comply.